COMMENTARY

Medical Malpractice: Can We Rescue a Decaying System?

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The Patient Protection and Affordable Care Act (PPACA) was passed in March 2010 and has now entered the slow process of implementation. It should be remembered that tort reform, although not a central component of the health care bill, was left a small window of opportunity as political maneuvering for acceptance of PPACA neared. In his speech before a joint session of Congress in September 2009, President Obama acknowledged that, although tort reform was not the sole answer to health care costs, he was open to exploring ideas that may better "...put patient safety first and let doctors focus on practicing medicine."[1] Because more than a year has passed since that communiqué, it is worth visiting where we are now in terms of medical liability reform, including current hurdles to any efforts for change and the direction future plans may need to take to implement a better system.

This commentary with review of current literature highlights the goals set out under the current medical malpractice system, discusses whether those targets are being met to date and whether conventional tort reform measures are situated to properly attain those goals, and suggests why future tort reform measures may better achieve those initial objectives. Challenges to successful implemention of new measures of tort reform in the current political climate are assessed, along with suggestions on how a more focused and concerted effort by both health care professionals and their patients may improve any future chance for success.

Structure of the Current Medical Malpractice System

It is important to grasp a basic understanding of the malpractice system as it currently exists to better appreciate the need for change. Physicians, hospitals, and other health care professionals may find themselves liable for wrongs under many different theories of medical malpractice, with the most frequent basis for suit involving the tort directed action of medical negligence.[2]

Liability under the tort theory of negligence requires specific elements be met.[3] First, a duty or legal standard of care must be established that corresponds to the care commonly provided by a reasonable and prudent physician practicing under similar circumstances. Some deviation, or breach of the duty, must in turn have occurred. There must be an injury suffered by the patient that requires attention. Second, a causal link must exist between the breach and the foreseeable injury suffered by the patient.

Given the complexity of the practice of medicine, expert witness testimony is often required to help the court decide whether the medical standard of care was breached and a causal link to an injury followed.[2] Concerns prevail regarding the reliability of expert testimony, yet it is difficult to determine to what degree such evidence may be biased by compensation or other reward.[4] In a recent article, 31 radiologists were asked to review a computed tomographic scan previously used to determine a defendant's liability.[5] Unaware of the involvement of the scan in the malpractice case, none of the "follow-up" radiologists described the finding that 4 plaintiff's expert radiologists had read as critical in establishing a breach in the standard of care. Several professional medical societies have used steps to help curb potentially unreliable expert testimony. As an example, the American Society of Anesthesiologists formed the Committee on Expert Witness Testimony Review in 2003 to review complaints that alleged lack of objective and impartial expert witness testimony offered by members of their organization. Because of the confidential nature of their review, the number of member anesthesiologists who have been disciplined by the committee is unknown.

Goals behind medical malpractice liability

Theories behind the need for a medical malpractice tort-based system include ensuring that the injured party is "made whole again" (through monetary award), the health care professional or entity causing the injury is punished (retribution role), and notice is served to other health care professionals before they mirror the same practices as the accused (deterrence role).[6] Physicians and health care facilities are considered best situated to bear the costs for compensating the injured.[6] Courts act to ensure that injured patients are remunerated if health care professionals are ineffective in self-regulating malpractice.[6] Plaintiff's attorneys serve as gatekeepers by discouraging nonmeritorious claims while ensuring that meritorious claims will be heard.[6] Because ready access to medical care is an important societal goal, medical liability insurers serve an important role in ensuring that patient compensation

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awards do not cause health care professionals to exit their medical practices.[6]

Are the Theorized Goals of Medical Malpractice Being Met Under the Current System?

If the current tort-based medical malpractice system is effective in meeting its assigned goals, it should be providing adequate legal assistance to patients who have been injured by negligent care. As it stands, the contemporary tort-based system appears to fall well short in this capacity. Localio et al[7] reviewed a sample number of patient admissions in the State of New York, one of the more litigious states in the Union with regard to medical malpractice liability at the time, and found that only 2% of patients who suffered adverse events involving alleged negligent medical care filed a malpractice claim. Using similar research methodology for review in the 2 less litigious states of Colorado and Utah, Studdert et al[8] described a comparable rate of malpractice filings.

A popular misperception among health care practitioners is that poor patients are more likely to file medical malpractice claims. During the 1990s, obstetricians and gynecologists reported performing a higher number of cesarean sections among a poorer patient population primarily because of a perceived heightened willingness for this group to file suit.[9] However, the fear that poor patients are more likely to sue for medical malpractice than their more affluent counterparts may not be well grounded. In the analysis of malpractice claim data from Colorado and Utah, Studdert et al[8] found that it was the poor, the uninsured, Medicare and Medicaid beneficiaries, and the elderly who were least apt to file suit. The authors suggested that, because this subset of potential claimants offered little chance to collect large sums through lost future wage damage awards, plaintiff attorneys may be less inclined to help represent them. This theory may be bolstered by data showing that, for every dollar awarded by the court to help make the injured patient whole again, more than half covers legal fees instead.[10]

Along with failing to effectively reimburse the injured patient, the current tort-based medical malpractice system has fallen short on its goal to punish and deter negligent medical practice. In brief, any system initially designed to police negligent provider care can only succeed in its mission if the claims under its review consistently involve adverse medical practice.

Concern arose as early as the 1990s that malpractice claims were being filed primarily on the basis of the likelihood of high damage awards, rather than on the existence of negligence. In a multivariate analysis of 51 medical malpractice cases, the severity of the disability suffered, in this case permanent disability, rather than the existence of negligence per se, was the motivation behind filing of the claim.[11] A later study by Studdert et al[10] again suggested that a significant number of medical malpractice court decisions were not reliably linked to the presence of negligent provider care. A retrospective, objective, and expert medical review of 1406 prior court decisions revealed that the court had properly ruled only 75% of the time by either correctly awarding damages in which negligence had caused injury or refusing to offer damages when no negligence existed.[10] The remaining 25% of the time, the court had failed by either awarding monetary damage to the plaintiffs suffering no medical negligence or failing to award compensation when negligence was the cause for injury.[10] Other reviews have suggested that the small percentage of filed claims (14%-30%) that ultimately receive compensation further reflect the capricious nature of the current medical malpractice system.[12] These results and others like them breed concern that current negligence-based–tort systems are largely ineffective in both compensating injured patients who are due and curbing the provider practices that resulted in the injury.

Are Current Day Tort Reform Measures Helping to Attain the Goals of Reducing Medical Malpractice?

Discussions surrounding tort reform measures in the United States often coincide with times of medical liability insurance crisis. During the 1970s, fear existed as to the availability of insurance and during the 1980s as to its affordability; while the turn of this century and onward has fostered concern over both availability and affordability.[13] Following the rapid rise in malpractice insurance premiums (more so in states with no caps on damage awards) beginning in 1999, the federal government became concerned about the impact such an increase may have on patient access to health care.[14] The government's own analysis concluded that no single source or event could fully explain the cause for the acute rise in premium costs.[14] Instead, several factors likely combined to escalate premium rates. Investment income for insurance contractors declined between 1998 and 2001 as returns on stock and bond portfolios fell.[14] Competition among the few remaining insurance providers during the 1990s had caused them to whittle down their resources to such a degree that they became relatively unprofitable.[14] Malpractice liability insurance suppliers purchase policies themselves to help offset their business risks.[14] These re-insurance rates increased rapidly as well, leaving companies to pass on these costs to policyholders through higher premiums.[14] Because of the lack of reliable data available to the government for review, the impact that high injury awards in states without caps had on overall liability premium rates could not be accurately quantified.[14]

Conventional tort reform measures typically fall into 1 of 3 general categories: limitations on access to the courts, modification of liability rules, or damage award reform.[6]

Conflicting evidence remains as to the consistent impact conventional tort reform measures have on reducing malpractice claim frequency, claim payout amounts, or lowering the medical liability insurance premiums paid by practitioners.[6] Guirguis-Blake et al[15] linked the outcomes of nearly 45,000 malpractice claims with whether the states in which they originated had 1 or more of 10 conventional tort reform measures in place. The only reform measure producing any variation among states was whether caps existed on damage award legislation. The disparity seen among states having damage cap laws decreased payout amounts but failed to offer any corresponding mitigating influence on claim frequency.

It can be argued that, if effective, implementation of conventional tort reform measures should decrease the fear of liability reported among health care professionals. Carrier et al[16] surveyed physicians, asking whether they increased their use of medical technology, ordered more tests, or commonly consulted other physicians to primarily lessen the risk of malpractice suits. The physicians were also queried as to their daily and long-term concerns for being named in a malpractice suit. The researchers then matched the physician responses to the areas in which they practiced regarding implementation of specific tort reform measures, frequency of malpractice claims, damage award amounts for those claims, and prices charged for malpractice insurance premiums. Results revealed little correlation among a physician's fear of liability or defensive medical practice and the liability environment in which he or she practiced. The greatest difference among physician concerns was linked to malpractice insurance premium rates; however, the percentage of physicians fearing liability while practicing in states that have the highest premium rates was only 5.4% higher than the concern raised among practitioners residing in the lowest premium rate states.[16] The beneficial impact that certain tort reform measures had on lessening physicians' fears also remained relatively small, as reflected by only a 4.0% variation among physicians practicing in states with or without total damage caps.[16]

Although studies by Guirguis-Blake et al[15] and Carrier et al[16] showed a positive yet small impact of damage award legislation, I am unaware of any comparative research evaluating the influence that high damage award requests play on physicians' fears vs the unease felt by simply being named as a party to a suit. If anxiety over the size of medical malpractice liability damage awards plays a significant role for physicians despite carrying liability insurance, caps on damages could help mitigate the emotional burden felt when a claim is filed. Perhaps an indirect measure of the impact that damage award caps have can be reflected by both the increase in the number of malpractice liability insurance companies (up from 4 to 19 in 1 year) and physicians (up 5% in <2 years) entering the State of Texas after implementation of a $250,000 cap on noneconomic damage awards in 2003.[17]

Current Day Hurdles to the Argument for Continued Conventional Tort Reform

Surveys have consistently shown that a high rate of defensive medicine is being practiced in the United States, allowing some to argue that more comprehensive tort reform measures would decrease wasted health care expenditures.[18] However, debate continues as to the true burden that defensive medicine costs and other legal-related costs place on rising health care expenditures in the United States.[18,19]

A recent publication by Mello et al[20] analyzed the expenses involved in the conventional medical liability system. Indemnity payments to injured plaintiffs, administrative expenses for attorney and court-affiliated costs, and an estimate of the cost of defensive medicine totaled approximately $55 billion. Although not an insignificant sum, most attention instead centered around the small impact (2.4%) that legal-related costs had on the total annual health care expenditures in the United States.[20] With that said, defensive medicine may impact more than health care spending alone. Concern has been voiced that defensive medicine practices may put patients at increased risk of undergoing unnecessary procedures and may even unintentionally set a new legal standard of care based on the addition of tests.[18,21,22]

Returning to the argument concerning health care spending alone, any suggestion that better management of liability-related costs will significantly help to decrease total expenditures is analogous to one attempting to direct "...the hair on the end of the tail" of the dog rather than controlling the entire tail itself.[23]

Regardless of the ongoing debate over the downstream effects of defensive medicine practices, if health care professionals argue that added tests and consultations are a primary result of liability fears, conventional tort reform measures should curb some of these "shielding" practices. A 2009 privately funded national survey of 3000 physicians offered further confirmation of the high rate of defensive medicine being practiced in the United States (92% of the 3000 physicians polled reported practicing defensive medicine).[21] Perhaps of more interest was that rates of defensive medicine being practiced in states that have tort reform measures, such as caps on damage award payouts, differed little from states that have no limitations on monetary awards.[21] This lack of cause and effect between

defensive medicine practices and tort reform implementation is further strengthened by the study from Carrier et al[16] that showed little change in defensive medicine rates among physicians practicing in states with conventional tort reform legislation in place.

A potentially fatal legal blow was recently suffered by those hoping for more comprehensive implementation of caps on damages as a means of conventional tort reform. Early in 2010, the Illinois Supreme Court ruled that an Illinois state statute restricting the judiciary's right to circumvent damage cap limitations in extenuating circumstances was unconstitutional. The court did offer some solace in allowing the state government the opportunity to rewrite the statute in such a manner as to allow the courts flexibility in calculating total damage award amounts for particular types of injury claims. Only time will tell as to what future impact the Illinois Supreme Court decision may have within the State of Illinois and for other states that already have or are contemplating damage cap legislation.[24]

Hope For The Future?

Current tort reform measures have been described as simply "less of the same system."[23] Physicians remain fearful of malpractice suits and continue to practice defensive medicine despite conventional tort reform legislation. For patients, contemporary reform measures have made it increasingly difficult to bring suits after truly suffering injury.[23]

Any future hope for valuable changes in the tort-based system will likely need to incorporate more comprehensive system reform. Proposals include alternative mechanisms of dispute resolution, removing negligence as a basis for judgment, and shifting legal responsibility away from the health care practitioner to the health care entity instead.[6]

Early Disclosure Reform Measures

Early disclosure reform envisions patients and health care professionals working together to resolve complaints quickly, often through private agreement contracts.[6] These types of programs are not entirely new concepts. Hoping to encourage disclosure practices, many states have already implemented legislation that offers degrees of legal protection to health care professionals who communicate with their patients after an adverse incident.[25,26] However, debate over the effectiveness of these statutory measures continues.[25] Many current state laws fail to require the disclosure of information that patients most wish were communicated. Furthermore, even if the desired information was passed on, many of the conventional disclosure laws may fail to effectively protect the physician's statements from the risk of future liability.[25] Of further note, because health care professionals are traditionally trained to demand only perfection of themselves, they are less likely to disclose information of their failures and the adverse outcomes that may follow regardless of the legal protections that may exist.[27] Apology legislation is often written in such a manner that it is difficult for health care professionals to accurately determine what is and what is not protected from being used as an admission of guilt during a future suit.[27] Health care professionals also fear that, although the specific language or act of disclosure may be protected from an evidentiary standpoint, the very act of communicating will send out an alert that could precipitate a suit that would not have otherwise arisen. Potentially adding to the concerns voiced by practitioners, Perez et al[28] failed to show a comparative decrease in the rate of malpractice claims filed in states that have apology/early disclosure legislation. Despite the aforementioned barriers, self-enactment of early disclosure by health care institutions has shown some promise (even without the support of protective state legislation).[29] The Lexington, KY, Veterans Administration system has seen both a decrease in claim payout amounts and a shorter time to resolution of claims since implementation of its early disclosure system in 1987.[30] Likewise, the University of Michigan Health System observed a decrease in claim frequency, payout amounts, and time to resolution of claims since executing its early disclosure program in the 2000s.[30]

A stronger union between effective state legislation and institutional programs may offer early disclosure programs a better chance for success.[25,29] The federal government has already voiced interest in this area. Senator Max Baucus (D-MT) proposed an early disclosure system in his 2008 white paper on health reform. In 2009, Senator Tom Coburn (R-OK) introduced early disclosure legislation under the Patient's Choice Act, and a later bipartisan effort was offered by Senators Baucus and Michael Enzi (R-WY) through the Fair and Reliable Medical Justice Act.[31] The US Department of Health and Human Services also appears committed to the pursuit of combining early disclosure and apology systems with future plans for liability reform; $23 million of federal funding has been awarded to pilot projects in this area.[25] However, because medical malpractice liability remains a state jurisdictional issue, any potential benefits of early disclosure and apology-based system reform realized from the results of these federally funded projects may be continually limited by restrictive state legislation.

Nonnegligence-Based Reform Measures

System reform measures applying nonnegligence-based standards of review include both no-fault administrative forums and arrangements offering automatic compensation for predetermined injury causing events.[6]

Under proposed no-fault administrative models, compensation is offered for injuries that are either avoidable or preventable.[10] An avoidable adverse event concept is derived through an evidence-based analysis of current medical literature and described as one that should rarely if ever occur under best practice standards.[32] On the standard of review spectrum, avoidable acts fall between negligence on one side and "automatic" strict liability on the other.[32]

Most of the proposals for avoidable-based systems of reform incorporate the idea of administrative health courts.[32,33] The notion of no-fault health court administrative systems of review is not new, having already been placed into practice in Sweden, Denmark, and New Zealand.[33] Although this notion was conceptualized as early as the 1970s, popularity in the United States has faltered somewhat until more recently.[32] Under such an arrangement, neutral experts in the field of medicine and epidemiology would assist administrative judges in their review and adjudication of claims.[34] A centralized database of past decisions would allow for greater efficiency in paying out claims for comparable avoidable events.[34] Economic damage awards would be calculated using accounting methods in existence under the contemporary negligence-based system while noneconomic awards would be set by a predetermined schedule of payment.[34]

Proposed advantages of an avoidable-based health court system largely stem from the more efficient and reliable compensation that flows from their evidence-based objective measure of review.[32] Practitioner and liability insurer concerns of the uncertainty in claim filing and award decisions described under the current negligence-based systems would be mitigated.[32] Although a broader range (and therefore number) of patients would be compensated using an avoidable/preventable standard of review, evidence-based objective measures would offer better control of total damage award payouts.

Perhaps the most compelling advantage flowing from a no-fault system is better promotion of patient safety measures.[29,32,33] Unlike the negligence-based system, which breeds physician silence because of fear of guilt and blame, an avoidance-based model would encourage communication to optimize future patient care.[32] Under a no-fault avoidance-based arrangement, health care professionals would have financial incentives to follow best practice standards to limit injury payout.[32] A central repository of claims reviewed with evidence-based medicine in mind would offer a more valuable and reliable pool of data for future study of patient safety compared to the current collection available in the National Practitioners Data Base.[32]

The benefits of greater reliability and objectiveness seen with an administrative health court arrangement comes with a risk that certain protective measures inherent to a jury-based system may be lost. Without jury involvement, local community input into regulating quality of health care may be absent.[34] The possibility of unmonitored bias of administrative judges toward the health care professional's interests at the expense of patient's concerns, or vice versa, is another added risk.[34]

A second type of no-fault–based reform system allows automatic compensation for injuries arising from medical practices falling outside preset protocols and guidelines.[34] Also under this arrangement, health care professionals would be protected from liability ("safe harbor") when the care they offered followed preset clinical practice guidelines (CPGs).[31,34] Unlike the current negligence-based system, the standard of review under the automatic compensation arrangement would be set before the injury.[34] Clinical practice guidelines would be derived through evidence-based research of current best practice literature, thereby forming a better union with patient safety initiatives.[32,34]

Congress has shown interest in evidence-based no-fault compensation schemes, as reflected by Senator Ron Wyden's (D-OR) introduction of the Healthy Americans Act in 2009. Under his proposal, the current negligent-based process of adjudication would remain, but a reputable presumption that care was proper would be created if it adhered to evidence-based medical practice (Credible Comparative Effective Research [CER]).[31] Included in the passage of the American Recovery and Reinvestment Act in 2009 was $1.1 billion in federal government funding for CER pilot projects.[31]

Certain challenges exist with implementing a no-fault evidence-based system. Clinical practice guidelines are only effective in judging whether the standard of care was met if they exist at time of review and there is ready agreement as to the accuracy of their content.[34] Because the content of CPGs is formed from expert opinion, the risk of inconsistent and conflicting analysis is real.[34] Furthermore, if no particular CPG accurately fits the scenario causing injury, claim reviewers may disagree as to which CPG best reflects the standard surrounding the patient's course of injury.[34] As mentioned previously, the risks of the loss of lay jury input into community standards for health care must also be considered.

Enterprise Liability Tort Reform Measures

Proposals that involve what has been labeled *enterprise liability* shift legal responsibility from the individual practitioner to the health care entity (eg, hospital or clinic). Because responsibility for compensating the injured patient would fall solely on the health care entity, economic incentives would exist to appropriately monitor and discipline substandard care.[10] Such proposals would likely work best

in group practice arrangements in which health care professionals are either employed by or have close administrative and financial ties to a limited number of health care facilities. Recent trends in physician employment demographics suggest that more practitioners are opting to leave solo practices to affiliate with hospitals and clinics.[35] Perhaps this migration will offer enterprise liability the very foothold it needs to become a more viable option for future tort reform.

Where Do We Go From Here?

Although some have suggested that President Obama's offer to explore tort reform concerns was insincere and only driven by a need for easier passage of health care reform, the result may have produced an appreciation that a better system is required to help mitigate avoidable medical errors and the associated legal consequences.[36] Earlier in 2010, the Agency for Healthcare Research and Quality (AHRQ), a component organization under the US Department of Health and Human Services, awarded $25 million in grants through the Patient Safety and Medical Liability Reform Demonstration to several pilot projects studying proposals for improving patient safety and medical liability reform.[36,37] Two million dollars was allocated to the RAND Corporation to evaluate the results of the pilot projects at their conclusion and to help guide long-term solutions to current negligence-based liability systems.[38] The AHRQ director Carolyn Clancy pointed out that these demonstration projects "will fundamentally give us a better evidence base" to reduce errors, better patient safety, and lessen lawsuits.[36] Clancy acknowledged the connection between liability reform and safety when she mentioned that "[t]his is a huge opportunity to make care safer and that's going to be a home run for everyone."[38]

The optimism that AHRQ, other government officials, patients, and health care professionals alike may have for current efforts to thwart problems with the medical liability tort system may be somewhat premature. The current financial and political climate in the United States appears far from receptive to a translocation of a negligent-based tort system to one involving a no-fault standard. Organizational and financial efforts by trial lawyers across the United States have offered a formidable opponent for tort reform measures.[39] Although physicians and physician organizations have certainly contributed significant money to political campaigns, their legal counterparts are both more organized and aggressive in their approach.[39] The political action committee (PAC) of the National Association of Trial Lawyers alone has contributed more than $33 million to both federal and state political campaigns.[39] Combining legal organization contributions with individual attorney donations, legal professional efforts have exceeded the combined donations of hospitals, physicians, pharmaceutical companies, and health care organizations.[39] In addition, the trial lawyers' lobbying organizations have targeted their efforts toward the medical malpractice liability system as reflected by the $1 million they allotted to help fight against the implementation of tort reform measures into PPACA.[39]

Despite the fact that the current medical liability system has largely failed to adequately meet the legal and societal goals it set out to attain, it is unlikely that it will exit without a substantial fight. Reform will instead require a concerted effort by both health care professionals and patients who understand that the current system largely benefits lawyers at the expense of all others. Injured patients fail to receive the representation they are due while physicians are limited in their efforts to use the system to improve the safety of care. The arrangement compensates only those injured whom plaintiffs attorneys have decided offer acceptable financial gain. The rest of the injured are neglected, neither receiving their just compensation nor adding to any beneficial gain that may arise from disciplining the medical practices that caused them injury. Furthermore, this selective process drives health care professionals to believe that the liability system is motivated by financial reward rather than an accurate critique of their care. Perhaps the failures of the current malpractice tort system can best be highlighted by the results of a recent national survey of physicians showing that, although 9 of 10 agree that patients injured as a result of negligent care should receive compensation, many continue to view their patients more as adversaries than partners.[21]

The type of effort required by those who have a considerable stake in the game (physicians and patients alike) includes a willingness to fight for implementation of early disclosure systems, no-fault based arrangements, or enterprise liability collectives despite negligent-based tort law remaining in place. Subtle but effective support for change may come from the findings of those federally funded pilot projects exploring various system-based methods of injury compensation. The natural link that system reform has with nurturing patient safety will be an important component of any argument. A recent technical report published by the RAND Corporation suggested a correlation between patient safety interventions in the State of California between 2001 and 2005 and decreasing volume malpractice claims filed.[40] The authors of the report acknowledge that despite these trends, current malpractice laws that place physicians at risk for open discussions about causes of injury may have a "...perverse effect of detracting from broader patient safety efforts." Combining the need for liability reform in a way that furthers, rather than detracts from, ongoing efforts to improve patient safety may be the very formidable offense required to counteract the large and organized attacks against tort reform offered by lawyer groups. It remains to be seen

whether patients and society as a whole will accept that, although medical injuries remain a concern and have not been effectively mitigated under the guises of contemporary negligence-based liability, a more effective system exists. A new system should provide compensation for the injury suffered while at the same time work to reduce the likelihood that the behaviors and practices that caused the injury will resurface in the future. Taking the moral and ethical high road as a profession and continuing to do right by our patients perhaps is the best argument we can muster for needed tort reform. Or as the vice provost of the University of Texas at Austin, and a professor of law, has stated, "[w]e need to move the process of resolving medical errors away from the courtroom and closer to the bedside."[36]

Conclusion

Current tort reform measures have fallen short of correcting many of the failures inherent to the medical malpractice system. The PPACA may offer a new opportunity to fix the system so that it better serves patients and health care professionals alike. Any future reform should involve system modifications that better correlate with patient safety measures

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